TUALATIN EYE ASSOCIATES

Patient Intake form *10/1/2024*

Sal **First Name** **MI** **Last Name** **Preferred Name** **DOB** **Last 4 SS#**

Mailing Address **Cell Day** **Phone Home** **Other** **Guardian**

E-Mail:

Emergency Contact **Name** **Relationship** **Phone**

VISION INSURANCE

Vision Insurance **Insured Name**

Insured's ID **Insured's DOB**

Insured's Employer **Insured's Last 4 SS #**

MEDICAL

Medical Insurance **Insured Name**

Insured ID # **Insured's DOB**

Group #

If you have a secondary policy, let us know!!!

HIPPA Notice and Acknowledgement

I acknowledge that I have been provided or had explained to me Tualatin Eye Associates ' HIPAA Notice of Privacy Practices and agree to continue my care with Tualatin Eye Associates under the terms of the HIPAA policy.

Signed _____ Date _____

Spectacle Prescription

At the conclusion of your *refractive examination* you will be given a copy of the prescription IF it is determined that glasses are beneficial. Signing below acknowledges receipt of the prescription.

Signed _____ Date _____

Contact Lens

Contact lens wear is safest when healthy habits are followed. The CDC & your doctor here need you to know that examinations are indicated at least once per year, that untreated eye infections can damage eyes or cause blindness. You should not ignore these symptoms: pain, redness or blurry vision. The FDA advises purchasing contact lenses only with a current prescription, we will not authorize expired prescriptions

A contact lens fitting is a professional service separate from the routine vision exam. The fitting includes the trial lenses and any follow-up appointments to provide you with a contact lens prescription. By signing below, you acknowledge that you can use your insurance benefits to cover the contact lens fitting, OR you will pay for the contact lens fitting at the time of service.

Signature of patient / responsible party _____ Date: _____

Do you currently wear contact lenses? _____ What Type/brand? _____ Daily / 2 week / 1 month

Tualatin Eye Associates Financial Policy

Understanding your benefits- TEA encourages all patients to know and understand their vision and medical insurance plan. You are responsible to check with your insurance company before being seen to make sure you do not need a referral and/or authorization. If an authorization / referral is not received prior to your visit you may be financially responsible for part or all of the charges related to any visits with us. As a courtesy we will bill your insurance company pursuant to the insurance information you provide us. There is no guarantee of payment from your insurance company and you are ultimately responsible for any balance due.

Any insurance benefits and co-pays are due at the time of service for both vision and medical appointments. Co-pays and balances for glasses and/or contacts lenses are also due prior to ordering. We can also assist in payments plans through Care Credit for any and all services, please ask a staff member

I understand that I am financially responsible for all charges whether or not paid by my insurance(s). With my signature below, I acknowledge and have read and understand the above information.

Signed _____ Date _____

☐ Signed by patient ☐ Signed by patient representative, relationship: _____